Conclusion

Chapter 4

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within the North Carolina Department of Health and Human Services asked the North Carolina Institute of Medicine (NCIOM) to convene a task force to review the state's current suicide prevention and intervention system and identify strategies to enhance the system to better meet the needs of North Carolinians. The Task Force focused on identifying key elements of a statewide suicide prevention and intervention plan. This final report provides a description of existing services and gaps in the current system, and includes eight recommendations to ensure that a statewide suicide prevention and intervention plan is adequate to meet the needs of North Carolinians.

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Suicide death is one of the top 10 leading causes of death for people ages 5-64 in North Carolina. Each year more than 1,000 North Carolinians die from suicide, more than 6,000 people are hospitalized due to self-inflicted injuries, and more than 8,000 are treated in emergency departments.[1] Suicide deaths in the state resulted in more years of potential life lost for individuals under age 65 than homicide, congenital abnormalities, cerebrovascular disease, human immunodeficiency virus (HIV), or diabetes mellitus.[2] What distinguishes suicide deaths from most other deaths is that suicide deaths are entirely preventable.

Many people who die by suicide have an underlying mental illness or substance use disorder. National data suggest that 90% of suicides are associated with some form of mental illness.[3] In North Carolina, 37% of the males and 67% of the females who died by suicide from 2004-2008 were in current treatment for a mental illness at the time of their death. Others had indications of mental health problems.[1] However we know that the North Carolina data is likely to be an underreporting of the connection between suicide deaths (or suicide attempts) and mental health or substance use disorders. The North Carolina Violent Death Reporting System relies on law enforcement interviews with survivors (those who knew the victim) to try to gather background information about suicide deaths, and the people who provide the information may not know, or feel comfortable revealing, the underlying mental health or substance use status of the person who died.

This report focuses on the role that the state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Medical Assistance (DMA) can play at the state level in reducing suicide deaths and suicide risk. The report also focuses on the role of Local Management Entities/Managed Care Organizations (LME/MCOs) and contracting behavioral health providers in helping identify people at risk of suicide, and to ensure they get into appropriate evidence-based crisis services or treatment. This plan comes at a critical juncture as North Carolina transitions its publicly funded MH/DD/SA system from a loosely organized, fee-for-service system to a more tightly coordinated managed care system. DMA and DMH/

DD/SAS are holding the new LME/MCO entities to higher standards and have enhanced performance requirements to include community engagement (i.e. engaging community partners), building an adequate network of qualified providers to meet the MH/DD/SA needs of people in their service area, and quality management responsibilities to ensure that high quality services are being delivered. These new standards can also be used to support the development of a more effective suicide prevention and intervention system at the local level.[4] While the plan focuses primarily on the role of LME/MCOs and contracting providers to prevent and reduce suicide risk, it also includes recommendations aimed at primary care medical homes within the Community Care of North Carolina (CCNC) networks. Primary care professionals are uniquely situated to help identify people who are contemplating suicide or otherwise at risk.

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We know that effectively reducing the number of suicide attempts and deaths will require new and strengthened partnerships across agencies. Thus, we need to create a statewide plan that includes all the state and community partners involved in suicide prevention, early intervention, crisis services, treatment, recovery supports, and postvention services for survivors (Recommendation 1).

This state suicide prevention and implementation plan cannot realistically be implemented immediately. As a first step, the state and the LME/MCOs should identify one or more staff members who will help coordinate the implementation of the state suicide prevention and intervention plan (Recommendation 2).

Ultimately, the state and local LME/MCOs should develop suicide risk management protocols for use by the state, within each LME/MCO, and with contracted behavioral health providers. The suicide risk management plan should include, but not be limited to:

- An outreach and education plan to educate the public and gatekeepers about suicide and how to identify people at risk and refer them to appropriate services.
- An evidence-based screening tool to determine level of suicide risk.
- Requirements for when and how often people should be screened for suicide risk and the criteria that would trigger a more comprehensive suicide risk assessment.
- Identification of an evidence-based suicide risk assessment that must be used, or requirements for the information that should be gathered as part of a more comprehensive suicide assessment tool.
- The protocol to ensure people are linked to appropriate crisis services.
- Requirements for what should be included in a person's crisis safety plan.

- Care management protocol to ensure that people successfully transition from one level of care or one behavioral health provider to another.
- Mechanisms to ensure that people at high risk of suicide are linked to professionals who can offer appropriate evidence-based treatment.
- Information about the types of recovery supports (including natural and peer supports) that should be available once the immediate crisis has been successfully resolved.
- Mechanisms to identify people who were touched by suicide death, to offer appropriate postvention services.

The suicide risk management plan should also ensure that clinical and nonclinical staff receive appropriate training to recognize people who are at higher risk of suicide, and that behavioral health professionals receive the training needed to provide evidence-based treatment. The local suicide risk management plan should also include requirements for postvention services for family, friends, and others who were touched by the suicide death of someone they knew (Recommendations 3-8).

Now is the time to act. We have lost the lives of too many North Carolinians by failing to invest in suicide prevention, early intervention, a coordinated crisis response system, and by failing to provide evidence-based treatments, recovery supports, and postvention services. We have the building blocks for an effective suicide prevention and intervention system; what we have historically lacked is an organized focus on this issue. This plan provides the blueprint for a more effective suicide prevention and intervention system, targeting people with mental illness or substance use disorders. By implementing this plan, we can go a long way to reduce unnecessary deaths and hospitalizations and improve the well-being of many North Carolinians.

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References

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